HAAD CLAIMS & ADJUDICATION RULES

Including the Mandatory Tariff Pricelist Application Rules.

Version: V2012

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1 Purpose and Scope

1.1 Document Purpose and Scope.

- Rules included in this document are built on the "Rules for Claiming under the Basic Product Pricelist" which was part of the previous Basic Product Pricelist (former description of the Mandatory Tariff file). Hence content of this document shall supersede any and all rules previous versions might have included.
- This document complements the Mandatory Tariff pricelist; explaining its content, and sets the claiming rules of its use for inpatient, outpatient and ambulatory encounters. Notwithstanding, contents of this document shall not be viewed or utilized in isolation from: (1) Circulars and Standards published on HAAD's website, (2) HAAD's Data Standard, (3) Clinical Coding Steering Committee (CCSC) decisions, (4) Standard Providers Contract (SPC) provision and /or (5) the DRG Advisory Panel decisions. In the event of any conflict between the content of this document and the Law and Rules and the aforementioned governance; the Law and Rules and the governance shall take precedence.
- Also, content of this document and the Mandatory Tariff Pricelist shall not cancel, limit, or contradict with any mandatory benefit defined as a minimum coverage by the Abu Dhabi health insurance law, and shall be interpreted within the context of law and to the benefit of the insured.
- The Mandatory Tariff pricelist and the rules included herein are applicable to all health insurance products regulated by the health insurance scheme.
- It also applies to healthcare entities, providers and payers, approved by HAAD to participate in the health insurance scheme.

1.2 Mandatory Tariff Pricelist Purpose and Scope

- The Mandatory Tariff is the exhaustive pricelist for the Basic Product Plan.
- Mandatory prices correspond to the Gross Amount due to the healthcare providers for services performed for insured patients; Patients will need to pay a Patient Share while the payer is to pay the remaining Net Amount.
- The process of claiming shall not alter the benefits coverage for members, hence in the absence of defined code for the dispensed drugs or provided supplies, products or services: Closest unlisted code can be used for claiming supplies, products or services, code A9150 "Non-prescription drugs" or J3490 "other unclassified drugs" for the drugs; an observation must be reported in the eClaim as defined in Routine reporting requirements published on https://www.shafafiya.org under Standards / Reporting requirements / Routine reporting/ Reference = " UnlistedCodes" .

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1.3 Updates and Revisions

- This version of the Mandatory Tariff shall be made effective on the date stated in section 2 of this document.
- Future updates of the Mandatory Tariff and HAAD Claims and Adjudication Rules updates, shall be implemented as per the following schedule:
  - There shall be **one MAJOR annual update**, to the Mandatory Tariff Pricelist and HAAD Claims & Adjudication Rules. The major update shall aim to:
    - Incorporate standard codes: ICD 9 CM, CPT, CDA, HCPCS addition, deletion or description update released by AMA and CMS. And / or non-standard codes: Service Codes, released by HAAD Health System Financing (HSF) Dept.
    - Wide-scale services and products prices update based on the revised CPT codes RVUs, Demand and Supply, Market Trends and other Economic Factors.
    - Update the Claims & Adjudication Rules to align with the strategic objectives, latest claiming and adjudication practices and governance.
    - Include updates in this revision which shall be published subsequent to CCSC review and approval of changes in the standard codes, IR-DRG grouper software, and DSP revision and approval of the changes to the Data Standard, if required.
  - **Next MAJOR Annual update** will be Mandatory Tariff version V2015-XX. Due to its impact, the Major Annual update shall be made in effect after one month of consultation and Seven months of implementation by healthcare entities: Providers and Payers, and in compliance with the following schedule:
    - ***First week of March 2014***: proposed prices are published for two months of market consultation period. Comments and feedback shall be submitted in writing to HAAD at GPPB@haad.ae . Submissions must be specific, supported with price cost analysis, and other relevant supporting evidence for it to be accepted.
    - ***First week of July 2014***: Mandatory Tariff V2015-XX is published on HAAD website as final.
    - ***Jan 1st 2015***: Mandatory Tariff V2015-XX is made in effect, which grants the healthcare entities seven calendar months to adopt the prices and rules changes.
  - There might be **additional LIMITED updates, or periodical addendums**, to the Mandatory Tariff Pricelist and / or HAAD Claims & Adjudication Rules; following the recommendations of the DRG Advisory Panel, or other concerned panel established by HAAD in the future for this purpose. The updates, or periodical addendums, shall be limited to:
    - Update of the IR-DRG weights.
    - Incorporate standard codes addition, deletion or description changes and / or non-standard codes; without affecting the unchanged codes prices.
    - Limited-scale price update or pricing un-priced codes of supply, product or service, to accommodate changes in the market trends or other economic factors.
    - Update of the Claims & Adjudication Rules.
  - **Next limited updates or periodical addendums** schedule shall be established based on the recommendations of the DRG Advisory Panel, or other concerned panel established by

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HAAD in the future for this purpose. If no update or addendums is published, last published pricelist and rules shall remain in effect until the next update or addendum is published.

2 Implementation Rules

2.1 Effective Date:

- This update is a Major Annual update.
- Prices listed in the Mandatory Tariff pricelist version **V2012**, and the rules included herein shall be made in effect as of **October 15th 2012.** After the expiry of consultation period which started November 15th 2011.

2.2 Rules implementation

- The rules included herein shall be utilized for billing, adjudication and reimbursement purposes for claims with "Encounter.Start" date of **October 15th 2012** onward;
- Where no rule existed in prior versions of the Claims and Adjudication rules, and only in the event both Providers and Payers mutually agree, rules included herein can be retroactively implemented.

2.3 Code Implementation

- New Codes (update status = <N>) shall be available for encounter with "Encounter.Start" equal or greater than the Code effective Date. Healthcare entities: providers and payers, shall have the choice to include or not include the new Codes in their contractual agreement that is in effect.
- Retired Codes (Update Status = <E>) shall be permitted to be used for encounters with "Encounter.Start" less or equal the Code Expiry Date. Healthcare entities: providers and payers, shall not have the choice to use the retired codes after the expiry date.

2.4 Rates Implementation

2.4.1 Multipliers Ranges

- For priced services and for all inpatient DRGs,
  - For the Basic Product, prices and DRG weights listed in the Mandatory Tariff pricelist version **V2012** and IR-DRG Base Rate included in this herein, shall be implemented as stated;
  - For the other Products, subject to section 2.4.2 of this document, services' prices shall be set by the parties between 1 and 3 times of the HAAD Mandatory Tariff and the Basic Product DRG Base Rate- but not the DRG weight, which shall be used as- published and in effect on the agreement effective or renewal date.
- For un-priced or unlisted code, healthcare entities:
  - For all products, and unless otherwise stated, providers and payers must negotiate a reimbursement rate per service before concluding providing the service.

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- If no specific charge is pre-negotiated, provider must bill using the price of the most closely related drug, supply, product, procedure or service.

2.4.2 Multipliers Application Rules

- Medication/Drugs, blood and blood Products are not subject to 1 to 3 times the Mandatory Tariff range. *Discount application on the Medication and Drugs shall follow HAAD circular 20, dated March 12th 2009 and ministry of Health circular number 89, and UAE FEDERAL LAW NO: 4, 1983. Dated 2004 on the retail; however remain subject to the free market dynamics and the provisions of the contractual arrangement between the healthcare entities.*
- With exception Medication/Drugs, Blood and Blood Products, providers and payers are permitted to negotiate a set price per code, within the range of 1 to 3 times the Mandatory Tariff for the priced services, for the following codes sets:
  - **Un-priced CPT Codes.**
  - **Dental Codes.**
  - **HCPCS Codes. and**
  - **Service Codes.**
- For all other services and codes, providers and payers are permitted to negotiate multipliers per service category (Laboratory, Radiology …etc), or CPT codes range as outlined in appendix B, but not allowed to negotiate individual price per service code. Multiplier must fall within the range of 1 to 3 times the Mandatory Tariff, and be incompliance with the following rules:
  - **DRGs**
  - A single DRG Base Rate, Gap and Marginal, per provider branch or all branches, and Insurance company single product, bundle of products, or all products.
  - In the presence of TPA: A single DRG Base Rate, Gap and Marginal per provider branch or all branches, and the represented individual or all Insurance company per single product, bundle of products, or all products.
  - **CPTs**
  - Single multiplier for all CPT codes per Provider branch or all branches and Insurance company single product, bundle of products, or all products; In the presence of TPA: per Individual or all represented Insurance companies.
  - Single multiplier per CPT range, as defined in Appendix B of this document, per provider branch or all branches and Insurance company single Product, bundle of products, or all products. In the presence of TPA: Individual or all represented Insurance companies.
  - **Anesthesia codes**
  - Single Base Rate for all Anesthesia codes (00100-01999; 99100-99150), per provider branch or all branches, and Insurance company single product, and bundle of products, or all products; In the presence of TPA: per Individual or all represented insurance companies.

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2.4.3 Rate Update Implementation Options

- Tariffs agreed between the Parties shall be as set out in the relevant appendix in the Standard Provider Contract using one of the following options:
  - ***Variable Rates:***
    - Using the price of the Mandatory Tariff in effect at the time of agreement with or without multiplier,
    - The reimbursement rates shall be subject to the periodic price updates (Increase / Decrease) published by HAAD, while the multiplier will remain as negotiated.
    - The Government Subsidized Basic Product reimbursement rates shall always be set as Variable Rates, with a multiplier of 1.
  - ***Fixed Rates:***
    - Using the price of the Mandatory Tariff in effect at the time of agreement with or without multiplier, OR defined price per products or services; subject to price implementation rules.
    - The reimbursement rates shall not be subject to the periodic price updates (Increase / Decrease) published by HAAD; and such, prices will remain unchanged throughout the contractual period despite any update to the Mandatory Tariff HAAD publish.
    - For this option to be utilized, the relevant Appendix in the SPC shall clearly state the Mandatory Tariff version in use, e.g. V2012.

- At the time of renewal, and in the event that no negotiation was initiated, prices and DRG weights will follow the Mandatory Tariff in effect while the multiplier and the DRG Base Rate shall remain constant.

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2.5 Pay for Quality

- For other products than Basic Products, Insurance companies and Providers can agree to include Pay for Quality indicators in Appendix (IV) of their agreement.
- Examples of types of indicators in Pay for Quality program:
  1. **Clinical Outcome Quality Indicators**
     - Emergency Department visit to Admission ratio.
     - Hospital Acquired Diseases.
     - 30-day readmission
  2. **Administrative / Process Quality indicators**
     - Rejection Rate.
     - Resubmission Rate.
  3. **Customer Satisfaction.**
     - Patient Satisfaction rate.
- If mutually agreed to be included in the contractual agreement, the Pay for Quality program must be compliant with the following requirement:

2.5.1 Parameters for P4Q Indicators

- ***Must have a Meaningful Use***.
- ***Must have verifiable measurement***, through external and independent source agreed by both parties or centrally available via the Health Authority.
- ***Cost / Revenue neutral to the insurance companies***; whereby providers can obtain additional payment or reduction /refund of payment based on their performance against the performance of other providers offering the same service; but the net effect at the aggregate level must be cost/revenue neutral to the payer.
- Providers can offset reductions under one indicator by the good performance on other indicators; ***the net augmentation/reduction (additional payment or refund) shall be calculated against all the underlying indicators the provider was eligible for.***
- Where possible, the principle of ***"one indicator for all categories"*** shall be applied, however P4Q indicators should align with the respective characteristics of the provider's category. E.g. readmission rates will only be measured in hospitals***.***

2.5.2 Application of Pay for Quality

- **Scoring**: P4Q indicators should be subject to scoring mechanisms irrespective of the size of the facility.
- **Eligibility**. Each indicator will have individual criteria for eligibility; ie. "Overall patient satisfaction score" will be applicable only for hospitals that participated in the HAAD patient survey.
- **Scope.** The outcomes supplement/reduction will be applicable to all invoices included in the encounter type pre-selected, and has an "Encounter.Start" date within the agreed upon review period.

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3 Code Definitions:

3.1 Standard Codes

- Coding of healthcare products and services shall be in accordance with:
  - "HAAD Coding Manual for Hospitals and Other Healthcare Institutions" available at HAAD website https://www.shafafiya.org under Standards / Coding Manual, which includes:
    - ICD-9-CM (International Classification of Diseases, 9th revision) coding conventions,
    - CPT-4 (Current Procedural Terminology),
    - HCPCS (Healthcare Common Procedure Coding System),
  - IR-DRG codes rules as Defined by 3M,
  - Dental Codes (USC&LS) rules as established by the Canadian Dental Association, Unified System of Codes and List of Services,
  - GreenRain Drug Codes rules as set by HAAD Pharma/ Medicines and Medical Products Department, including MOH registered drugs.
  - The Coding Rules as established by HAAD for the non-standard "Service Codes" as listed in section 3.2 and Appendix B of this document. and
- All standard codes are defined and available for download from https://www.shafafiya.org under Prices/Mandatory Tariff. HAAD has Emirate-wide licenses for all standard codes sets.
- Non-standard codes are defined by HAAD Health System Financing Department to describe activity that is not unambiguously represented by an existing standard code.
- Selection and sequencing of diagnoses, service codes, procedures codes, dental codes or DRGs must meet the definitions of required data sets for applicable healthcare settings. Data Elements and HAAD Data Standards and Procedures are defined in https://www.shafafiya.org under Standards / Coding /Coding Manual.

3.2 Service Codes

- Service Codes are Abu Dhabi specific codes defined by HAAD Health System Financing Department and added to describe activity that is not unambiguously represented in other existing standard codes set.
- The conclusive list of the HAAD Service Codes, along with the codes long description, is set in Appendix A of this document. A tabular set of the Service Codes is also found in HAAD Mandatory Tariff V2012 File.

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4 Claiming Methodologies

4.1 Methodology per Encounter Type

- **Inpatient encounters;**
  1. ***Inpatient***: Is a beneficiary registered and admitted to a hospital for bed occupancy for purposes of receiving healthcare services and is medically expected to remain confined overnight and for a period in excess of 12 consecutive hours.
  2. Reimbursement of Inpatient encounters can follow one of the following methods;
     - i. Fee for Service (FFS) methodology, as defined in section 4.2. Or
     - ii. Perdiem (selected codes) with CPT, HCPCS, CDA and Drug Codes, as defined in section 4.3. Or
     - iii. Inpatient DRGs.
  3. On January 1st 2013, IR-DRG will become the only acceptable method of claiming for inpatient encounters in the Emirate of Abu Dhabi for inpatient encounters; refer to circular 49 for implementation date.
- **Ambulatory Surgical Procedures or Same Day Surgery:**
  1. Surgical interventions performed in Ambulatory Surgery Centers (ASCs) or Hospitals that is licensed / sublicensed, equipped and operated primarily for the purpose of performing surgical procedures and the beneficiary is medically expected to remain confined for 6 to 12 hours In a Day Care / Day Stay section of the facility, even if the patient remains in the facility past midnight.
  2. Reimbursement of Ambulatory Service encounters can follow one of the following methods;
     - iv. Fee for Service (FFS) methodology, as defined in section 4.2. Or
     - v. Perdiem (selected codes) with CPT, HCPCS, CDA and Drug Codes, as defined in section 4.3. Or
     - vi. Ambulatory DRGs.
  3. For the Basic Product Ambulatory Services shall be billed using the perdiems methodology - as defined in Section 4.3. For all other products, the used of any or all of those methodologies shall be permitted.
  4. HAAD, and at its own discretion, might decide to activate the ambulatory section (in part or in full) of the DRG system, or introduce a new prospective payment system that is analogous to the DRG system for the Ambulatory Services, following stakeholders' consultation and sufficient implementation time.
- **Outpatient encounters;**
  1. ***Outpatient:*** is a beneficiary who has not been admitted *at that encounter* a in the healthcare facility as an inpatient or ambulatory case, but is seen for diagnostic, therapeutic or observation services.
  2. Reimbursement of outpatient encounters can follow one of the following methods;

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vii. Fee for Service (FFS) methodology, as defined in section 4.2. Or
viii. Perdiem (selected codes) with CPT, HCPCS, CDA and Drug Codes, as defined in section 4.3.

4.2 Fee for Service

- "Fee for Service" model allows for services rendered to be separately billed and reimbursed, using the available codes sets approved by CCSC and HAAD.
- For Basic Product members, payment using Fee for Service (FFS) will be limited to services rendered in outpatient and "ambulatory surgical" setting; for the services that are not included in the Perdiem Codes definition, or has no claiming rule that restricts its reimbursement.
- HCPCs codes prices or negotiated rates are inclusive of the device / item costs, handling cost and provider mark-up.
- In the absence of unbundling[1], the Fee for Service (FFS) model allows for services to be coded and billed separately; subject to rules set by CCSC, HAAD or other acceptable coding references.
- Unless the code description or definition indicates the inclusion of other services, no code description or definition can be stretched by providers or payers to include other services that have distinctive and unambiguous defined codes.
- Following codes sets can be used for Fee for Service (FFS) claiming
  i. **Service Codes:** Limited to the following codes sets:
  - Main-Category 1 - Accommodation
    - Sub-Category 1.1. Room and Board
    - Sub-Category 1.2 Special Care
    - Sub-Category 1.3 Nursery
    - Sub-Category 1.4 Intensive Care
    - Sub-Category 1.5 Other rooms
  - Main-Category 2 - Perdiem
    - Sub-Category 2.1 Room Rate Difference.
  - Main-Category 3 - Consultations
  - Main-Category 4 - Operating Room Services
  - Main-Category 5 - Other Services

  ii. **CPT codes (including anesthesia codes):** All CPT codes that are active and available for billing purposes.
  iii. **HCPCS:** All approved and active HCPCS codes.
  iv. **Drug Codes:** HCPCS codes A9150 and J3490, in addition to Drug Codes set by Pharma and Medical Products section at HAAD.

[1] *Unbundling*: is the practice in which separate procedure codes are billed for procedures which are typically included as one code

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v. **Dental codes:** All approved and active USC&LS codes.

4.2.1 Fee for Service - Special Claiming Rules

4.2.1.1 Evaluation and Management (E/M) Codes:

- The Health Authority-Abu Dhabi has retired Service Codes 9, 10 and 11, hence are no longer available for billing purposes for claims with encounter start date of July 1, 2011, E/M Codes use is now mandatory. Refer to the Health insurance circular 33 on HAAD website: *www.haad.ae for* additional details.
- Reimbursement of doctor visit, shall be in accordance with the following rules;

I. Facilities which have achieved Coding Certification (listed at https://www.shafafiya.org under Dictionary / Codes / Licenses)
   - Bill for doctor visit using the available E&M codes and charges the differential rates as set in the Mandatory Tariff in effect for the Basic product, and negotiated differential rates (ranging 1 to 3 time the mandatory tariff) for other products.

II. Facilities which have not achieved Coding Certification shall:
   - **Until October 14th 2012[2],**
   - Bill using the lowest level (level 1) code of the applicable E&M codes type, can only claims a uniform rate of: AED 45 for the Basic Product, and negotiated rate of AED 45 -135, equivalent to a multiplier of 1 to 3 of the Mandatory Tariff, for other products.
   - Providers are required to report the proper E&M codes in a separate activity line but keep charges at a value of zero, as a prerequisite for reimbursement.
   - On a purely voluntary basis and at its own financial risk, the Insurance companies may choose to pay individual providers differential rates as if they had been certified; for providers who can provide proof of the following to the Insurance companies: (1) coding competencies and (2) signed agreement with one of the authorized audit companies to perform the audit.
   - **On October 15th 2012, onward:**
   - For the Basic Product, using the lowest level (level 1) code of the applicable E&M codes type, and only claim the rate set for the level 1 of applicable E&M codes type,. And negotiated rate of 1 to 3 of the Mandatory Tariff for the applicable level 1 E&M Code for all other products.
   - Providers are required to report the proper E&M codes in a separate (additional) activity line, but keep charges at a value of zero, as a prerequisite for reimbursement.

III. Newly licensed facilities, which do not have the required three months of billing history, are exempted from the certification requirement for E&M codes for the first six months

[2] HAAD circular 45.

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from receipt of the first patient; provided they meet the requirement of: (1) a valid Process Flow Map, and (2.) Proof of certified and/or experienced coder(s). And thus shall:

- Bill for doctor visit using the available E&M codes as per Circular 33; with differential rates set for the Basic product as set in the Mandatory Tariff in effect, and differential rates negotiated with individual payers for all other products. However,
- Should Coding Certification not be achieved by the end of the exemption period, the insurance companies has the right reclaim any aggregate amount paid above the uniform rate set for the uncertified providers.

- With exception of newly licensed facilities, application of the above rules shall be revenue cycle based, whereby providers shall be allowed to bill using the deferential E&M rates for all E&M activities with Encounter Start Date equal or greater than the 1st of the month in which the coding certification was availed. Whereas for the newly licensed facilities, the rule application shall be based on the activity and encounter start date.

4.2.1.2 Services Included in E & M Codes

- E/M codes may be used by all physicians and Clinicians[3]; subject to their scope of practice.
- Refer to the AMA coding guidelines and the CCSC Coding Manual for proper selection of E&M level, and services included in the E&M Codes.

4.2.1.3 E & M Services Not Separately Reimbursable

- The following CPT-4 codes for E & M services are not separately reimbursable if billed by the same facility, for the same patient, same principle diagnosis / chief complaint same on the same date - or within the subsequent week- of service. In such cases, for the following code combinations, reimbursement will be made only for the higher paying of the codes billed.

  i. New patient, office or other outpatient visit (99201 – 99205) and another new patient, office or other outpatient visit (99201 –99205).
  ii. Established patient, office outpatient visit (99211 –99215) occurring within 7 days from the initial New patient, office or other outpatient visit (99201 – 99205).
  iii. New or established patient, subsequent hospital care (99231 –99233) and new or established patient, initial inpatient consultation (992551 – 99255). Applicable only for the same date of service.
  iv. New or established patient, initial hospital care (99221 – 99223) and new or established patient, subsequent hospital care (99231 – 99233). Applicable only for the same date of service.
  v. E&M visit on the same day of endoscopy, minor or major surgery, unless significant, and separately identifiable beyond the pre-operative and post-operative work of the procedure".

[3] CCSC –item 057- this only refers to licensed healthcare professional as follows:
1. Registered School Nurse 2. Registered Nurses 4. Registered Midwife 5. Optometrist 6. Podiatrists 7. Chiropractic Practitioner 8. Osteopathy Practitioner

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- Calculation of the “Follow up within one week” starts from and includes the day of visit (ActivityStart); and shall be billed using Evaluation and Management of an established patient codes 99211 to 99215 at “0” value.

4.2.1.4 Surgical CPT codes

- CPT Surgical Section codes represent the documented surgical procedure; however by definition following services are always included in addition to the operation per se:
  - Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia;
  - Subsequent to the decision for surgery, same physician related E/M encounter on the date of procedure (including history and physical);
  - Immediate postoperative care, including dictating operative notes, talking with the family and other physicians;
  - Writing orders;
  - Evaluating the patient in the post-operative recovery area;
  - Typical postoperative follow-up care.
- Surgical Codes do not include supplies and materials, Anesthesia, Operation Room charges or Recovery Room or any service not otherwise specified above.

4.2.1.5 Anesthesia Codes,

- This claiming guide provides you with the claiming criteria for anesthesia services provided by HAAD licensed physicians.
- For the Basic product, and other product if claiming using IR-DRG, Anesthesia codes are used for cost reporting and outlier calculation.
- Following are the types of anesthesia eligible for separate claiming
  - i. Inhalation
  - ii. Regional, including:
    - Spinal (low spinal, saddle block)
    - epidural (caudal)
    - Nerves block (retro-bulbar, brachial plexus block, etc.)
    - Field block
  - iii. Intravenous
  - iv. Rectal
- The following types of anesthesia services are not eligible for separate reimbursement:
  - Anesthesia provided in conjunction with non-covered services
  - Administration of anesthesia by the surgeon or assistant surgeon
  - Local anesthesia
  - Standby anesthesia.

- Anesthesia time starts when the physician or anesthetist begins to prepare the patient for anesthesia care in the operating room or equivalent area and ends when the

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anesthesiologist is no longer in personal attendance, i.e., when the patient may be safely placed under postoperative supervision.

- Payment for the administration of anesthesia is based on the base unit value assigned to the procedure code, plus time units, multiplied by Base Rate.
  - **Base unit:** values have been assigned to each anesthesia procedure code and reflect the difficulty of the anesthesia service, including the usual preoperative and postoperative care and evaluation.
  - **Time Units:** Anesthesia time involves the continuous actual presence of the anesthesiologist. Time units are determined on the basis of one time unit for each 15 minutes of anesthesia, and provider's reports the total anesthesia time in minutes on the claim.
    Note: Time units are not recognized for code 01996 (daily management of epidural or sub-arachnoid drug administration).
- **Base Rate:** the fee schedule anesthesia conversion factor; 1 Unit = EAD 66.
- Example of anesthesia reimbursement calculation:
  - Surgery Repair of Cleft Palate, Anesthesia time = 2 hours.
    - Code 00102 (Anesthesia Repair of Cleft Palate) base units = 6.
    - Time units = 8 = (120 anesthesia minutes /15 minutes Time Conversion)
    - Base Rate = AED 66 = (Mandatory Tariff X 1)
  - Total Reimbursement of Anesthesia = (6+8)*66 = AED 924.

- **Anesthesia for Multiple Surgical Procedures;** Payment can be made for anesthesia associated with multiple surgical procedures. Reimbursement is determined by the base unit of the anesthesia procedure with the highest base unit value and the total time units for the total operative session. Claiming should report the anesthesia procedure code with the highest base unit value and indicate the total time for all procedures.
- **Aborted Anesthesia Procedure;** when surgery is aborted after general anesthesia induction has taken place, payment may be made based on three base units plus time. Anesthesia must be reported using unlisted Procedure code 01999, in addition to the in addition to the relevant anesthesia code. Refer to section 1.2 for claiming unlisted services.

4.2.1.6 Contrast and Radiopharmaceuticals Materials

- When an imaging or therapeutic nuclear medicine procedure is performed, separate reimbursement for Radiopharmaceutical materials shall be permitted if reported on the same date of service with a CPT code that requires Contrast or Radiopharmaceutical materials
- The Imaging codes eligible for separate contrast reimbursement are those that have mention of "with contrast" within their code description; Or codes in which clinical review determined contrast or radiopharmaceutical materials were required in order to perform the service.
- HAAD Drug codes shall be used for billing Contrast and Radiopharmaceuticals Materials.

4.2.1.7 Venipuncture and Injection Procedures

- Venipuncture (36415) is denied or paid based on the circumstances in which it is provided. Payment for Venipuncture shall be allowed only if an outside laboratory was utilized and the lab samples are drawn in a provider's office.
- Neither an injection procedure (96372-96379) nor a venipuncture (36415) should be reported with any diagnostic procedure code that involves the use of an intravenous contrast medium (e.g., do not report venipuncture code 36415 with 74400 for intravenous urography). These are considered incidental to the primary procedure.

4.2.1.8 Blood and blood products

- In pursuant of Decree # 40 for 2006 of the cabinet of the UAE, Blood and Blood Products prices are fixed, therefore are NOT subject to 1-3 times the Mandatory Tariff range for all products, but rather reimbursable at the rate set in the Mandatory Tariff pricelist.
- Blood and Blood Products prices are inclusive of Blood Unit cost, Cross Match, Antibodies Screening and Administration and handling cost.

4.2.1.9 Ophthalmology / Diagnostic eye exams

- Ophthalmologist has the choice to utilize the following E&M codes for eye care provided:
  - 99201-99205 Office or other outpatient services
  - 99241-99245 office consultations
  - 99281-99288 emergency department services
  - 92002-92014 General ophthalmological services
- The physician should select the code that represents the service needed based on the patents presenting problem. The documentation should reflect the examination billed, which shall be in compliance with the criteria set by the AMA Guidelines and the Coding Manual.

4.2.1.10 Wound Care

- When service provided is only a non-surgical cleansing of a wound without sharp debridement, with or without the application of a surgical dressing, the appropriate Evaluation and Management (E/M) codes should be used.
- The selection of the E/M service should be supported by the documentation of the appropriate components; and the non-surgical cleansing of a wound will be considered bundled in the E&M reimbursements, and has no entitlement for separate payment.
- If performed in the "Follow up within one week" period, non-surgical cleansing of a wound without sharp debridement might be separately reimbursable using the appropriate service codes (51-01, 51-02 and 51-03); for the following services appropriate CPT codes must be used: wound debridement, dressing for burns, and dressing change under anesthesia.

4.2.1.11 Comprehensive screening Codes: 50-01 and 50-02.

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- Reimbursement for codes 50-01 and 50-02 shall not be allowed if billed jointly or with CPTs 99381-99387; for the same patient and episode of care. In the event of being jointly billed for the same patient and same episode of care, reimbursement shall be limited to the "single" code that deems most appropriate.
- "E&M Follow up within one week" rule shall not be applicable to service codes 50-01 and 50-02. Hence, reimbursement shall be allowed for subsequent Evaluation and Management office visit or consultation, if deemed medically necessary. Nonetheless, subsequent Evaluation and Management office visit or consultation shall be subject to the E&M rules in effect.
- Coding and reimbursement of related subsequent services (including E&M) shall be based on the medical necessity determined by the initial screening outcomes or services prescribed by this standard. Whereby;
  1. Preventive medicine counseling CPT codes (99401 – 99420) shall be allowed for patients with established high to medium risk factors, or cases with non-definitive finding.
  2. For subsequent encounter after counseling was commenced, and where abnormal finding were detected; such encounters shall be billed and reimbursed under the insurance plan as a medical condition and not a preventive service.

4.3 Perdiem

- Codes that are defined as Perdiem are:
  - Subcategory 2.1: Room and Board
  - Subcategory 2.2: Intensive Care.
  - Subcategory 2.3: Nursery
  - Subcategory 2.4: Special Care
  - Subcategory 2.5: Long Term Stay
  - Subcategory 2.6: Observation, Day Stay and other rooms
  - Subcategory 2.7: Dialysis
- Unless otherwise specified, all per Diem are daily all-inclusive and shall be inclusive of:
  - Room and Board Charge, care equipment and systems specific to the special room type.
  - Evaluation and Management.
  - Routine Nursing and medical supervision charges.
  - All therapies (including respiratory therapy, all physiotherapy, nutritional therapy etc).
  - Radiology tests excluding MRI, CAT Scans and PET Scans.
  - Laboratory tests.
  - Anesthetist and anesthesia charges.
  - Operation Room.
  - Recovery Room.
  - Drug/pharmaceuticals:
    - For other than long term care: cost of single drug that doesn't exceed AED 1000 in accumulative cost during the entire length of stay.
    - For Long Term Care: all drugs regardless of its cost.

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- Products or supply:
  - For other than long term care: approved single products or supply (HCPCS) not costing in excess of AED 1,500.
  - For Long Term Care: all consumables, products and supplies regardless of its cost.
- For the Basic Product: all items which do not have a valid and covered code in the Mandatory Tariff pricelist.

- NICU, PICU, ICU, SCU and SCBU are inclusive of all the above but are exclusive of radiology tests, laboratory tests and all drugs.
  - In using the perdiems, providers shall only claim the rate set for the respective perdiem code, and any excluded services. For the services that are included in the perdiem code providers are required to report the proper codes as activity line but keep charges at a value of zero as a prerequisite for reimbursement. Encounters containing perdiem codes and have "Encounter.StartDate" **October 15th 2012** onward, must have observations as defined in Routine reporting requirements published on https://www.shafafiya.org under Standards / Reporting requirements / Routine reporting / Reference = "ActivityCost"[4].
- In 2012, the mandatory use of the per diem service code for the Basic Product, shall be limited to:
  - **Ambulatory Services (medical and surgical)**: codes 25-01 and 25-02 for the patient medically expected to remain confined for 6 to 12 hours.
  - **Outpatient assessment, examination, monitoring, treatment or therapy purposes:** Service code 24 for patients medically expected to remain confined for less than 6 hours.
  - **Long Term Care (LTC):** codes 17-13, 17-14, 17-15 and 17-16 – as defined. LTC Service Codes must be used in accordance to the HAAD Standard for Provision of Long-Term Care[5].
  - **Inpatient Dental Care**: Limited to emergency cases only. Using the appropriate code of perdiems with Sub-Category 2.1. Dental services not included in the perdiem, must be billed as Fee-for-Service.
  - **Transferred Cases:**
    - For Transfer patients between facilities (inter-hospital transfers) for the purpose of managing acute medical condition. Transfer Case definition doesn't apply to patient transferred to facilities or inter-hospital for Long Term Care..
    - Payment for transferred cases shall be in accordance with the following rules:
      - Transferring facility should bill and receive payment for Perdiem, using the designated Service Codes:
      - The receiving facility shall receive payment IR-DRG payment[6].

[4] Providers can start including the observations in the e-claim on voluntary basis prior to Oct 15th, however all healthcare entities are mandated to utilize the observation for billing and payment purposes as of Oct 15th 2012.

5 For reference see the Long Term Care Standard at www.haad.ae

6 Refer to IR-DRG claiming methodology, for details.

- For transferred patient encounters, data elements must be reported in accordance with the rules defined in HAAD Data Standard for transferred cases, which include but are not limited to: "EncounterStartType", "EncounterTransferSource", "EncounterTransferDestination", and "EncounterEndType".

4.4 IR-DRGs:

4.4.1 DRG Rules

- IR-DRGs are effective and mandated for the Basic Product for all Inpatient encounters with "Encounter.Startdate" **on or after 1 August, 2010**. For all other products IR-DRGs will be mandated and effective on[7] **January 1sr 2013.**
- DRG Weights included in Mandatory Tariff V2012 are calculated based on **Version 2.3 of 3M grouper; thus must not be used with any other older version or the grouper.**
- HAAD Standard establishing the Diagnosis Related Groupings System is available at HAAD website www.haad.ae , Policies and Circulars Section: Reference HSF/DRG/1.0, Approval Date Jun/2010.
- In the IR-DRG system, payment is fully inclusive of all procedures, services, consumables and devices utilized during services delivery by the provider in a single inpatient encounter. For e-claim submission under the IR-DRG prospective payment system:
  - All activities (services and procedures) shall be reported using the "Fee for Service" claiming methodology, as explained in section 4.2.
  - Activity.Net must be set to "zero" value for all Activities with the exception of the IR-DRG code, and service code 99 for the outlier payment.
  - For inpatient encounters with "Encounter.StartDate from **Oct 15th 2012** onward, must have observations as defined in Routine reporting requirements published on https://www.shafafiya.org under Standards / Reporting requirements / Routine reporting / Reference = "ActivityCost"[8].
  - For inpatient encounter with "Encounter.StartDate" from **Oct 15th 2012** onward, and for a) all Activities with "zero" value in the Activity.Net, and b) are NOT claimed to insurance must have observations as defined in Routine reporting requirements published on https://www.shafafiya.org under Standards / Reporting requirements / Routine reporting / Reference = "DRG-NotCovered"[9].
- Member Share (Co-pays and deductibles) are not affected by the DRG payment system and should be collected as normal.

[7] Reference: Circular 48: Schedule for Implementation of Payment System Updates.

[8] Providers can start including the observations in the e-claim on voluntary basis prior to Oct 15th, however all healthcare entities are mandated to utilize the observation for billing and payment purposes as of Oct 15th 2012.

[9] 9 Providers can start including the observations in the e-claim on voluntary basis prior to Oct 15th, however all healthcare entities are mandated to utilize the observation for billing and payment purposes as of Oct 15th 2012.

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- IR-DRGs are dependent on principal diagnosis and principal procedure; IR-DRG severity might be affected by the secondary diagnosis.
- In the event of several procedure being performed in the same encounter, the principal procedure shall be select based on the following hierarchy[10]:
  1. The procedure performed for definitive treatment; rather that one performed for diagnostic or exploratory purposes or was necessary to take care of a complication.
  2. In the event of two or more therapeutic procedures, then the procedure most related to the principal diagnosis.
  3. In the event two or more therapeutic procedures are equally related to the principal diagnosis, then the procedure with most resource intensity.
- Adjudication of claims payable using the IR-DRGs prospective payment system shall be in compliance with the Claims Adjudication and Pre-Authorization rules set in section 5 of this document, and HAAD Adjudication Standard published in December 2010. With the following DRG specific adjudication rule:
  - If the principle diagnosis is not covered condition under the insurance plan, Insurance companies shall have the right to deny the entire claim.
  - If the principle procedure is not covered. Insurance companies could exclude the Service, procedure or item, and pay using the recalculate DRG.
  - Secondary diagnosis coding shall follow CCSC published rules. Accordingly:
    - Secondary diagnosis(es) if relates to uncovered condition but has bearing on the current hospital stay shall not be excluded from the DRG payment
    - Providers shall refrain from coding a secondary diagnosis (es) that refer to an earlier episode that has no bearing on the current hospital stay, unless for chronic conditions and co-morbidities.
    - Diagnosis (es) not supported by coded services shall NOT be excluded by the Insurance companies during adjudication, as such diagnosis(es) might have influence on the length of hospital stay, or increased nursing care and/or monitoring. However, can be flagged for audit, and be subject to recovery if confirmed to be wrongly coded by the medical record audit.
    - Confirmed Coding errors shall be reported to CCSC for arbitration review and potential audit certificate cancellation of the frequent violators.

4.4.2 Payment Calculations

- Price For Basic Product, the **Base Rate is AED 8,500; the Gap is AED 50,000 and the Marginal is 60%.** For all other products, Base Rate, Gap and Marginal must be negotiated in accordance with the terms of the Standard Provider Contract.
- Unless the Split of DRGs payment rule applies, payers are liable for the complete DRG Base Payment only, unless the case hits the outlier:

[10] As defined in the CCSC Coding Manual

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i. **Base Payment**

- The Mandatory Tariff lists the relative weights. The exact base payment can be calculated by multiplying the base rate [x], the relative weight of the DRG (in 4 decimals) and rounded off to the full AED (no decimals) using the following formula:

Base payment = Base Rate * Relative Weight.

ii. **Outlier Payment:**

- Outlier payment acts as a "stop-loss" measure to protect providers from incurring losses while managing complex cases and calculated as follows:

Outlier payment = (Cost – (Base Payment + Gap)) * Marginal.

- Cost for outlier will be established by using the Mandatory Tariff prices regardless of the product, and the cost of the HCPCS as previously defined.
- Services that can be excluded from the DRG / DRG outlier payment shall be limited to:
    - Claiming Errors and duplicate charges, using simple and complex edits as defined in HAAD adjudication standard.
    - "Medically impossible" charges: services that couldn't have been provided due to:
        - Patient gender restriction.
        - Patient age restriction.
        - Patient previous medical history.
    - Not-covered item under the insurance plan.

iii. **Split of DRGs payment for encounters involving more than one payer.**

- Rules included in this section shall apply in the event of:
    - Inpatient encounter that extends beyond the expiry date of the policy, or New-born in-patient encounter that extends beyond one month coverage period through the mother's insurance, and where more than one payer is involved in reimbursement of the cost of a single inpatient encounter. And
    - Reimbursement of cost of the members' treatment is in accordance with the IR-DRG payment system.
- Single Admission is considered a single encounter thus shall be reimbursed as single DRG payment for the entire stay, irrespective of number of day's coverage limitation.
- For Newborn cases:
    - The cost of the Newborn treatment is to be billed separately from the mother's bill, but using the mother's insurance coverage.
    - Claiming for the mother treatment will be using the mother's insurance details and mother member ID.
    - Claiming for the newborn treatment will be using the mother's insurance details; insurance carrier and insurance benefits, BUT using the newborn's unique member

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ID. Newborn's member IDs (temporary or permanent) are to be made available by the payers in a reasonable timeframe from the time the request for the member ID is initiated, by the healthcare provider.

- Reimbursement for such encounter shall be in accordance with the following rules;
  - **Medical Cases (IM);** irrespective of the Length of Stay (LOS). Payer 1 will be responsible for the total DRG Payment
  - **Surgical Cases (IP) ;**
    - If the surgery was performed within the Payer 1 coverage period and no subsequent surgeries taken place post Member's Insurance Policy Expiry Date; Payer 1 will be responsible for the Total DRG Payment.
    - If the surgery was performed after the Member's Insurance Policy Expiry Date, the payment split of such encounter shall be determined as follows;

Payer 1 Responsibility = **Total DRG Payment*(X/Y)+ (((1-X/Y))* Total DRG Payment)*30%)**
Payer 2 Responsibility= **Total DRG Payment- Payer 1 Responsibility**
Total DRG Payment = DRG Base Payment + Outlier X = Number of Days covered by the Payer 1 Y = Total number of day of the Encounter (Admission)

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5 Adjudication and Pre-authorizations Rules

5.1 General Rules

- HAAD Health Insurance Adjudication Standard has established and mandates the Claims Adjudication Process and Rules for health insurance reimbursement in the emirate of Abu Dhabi. And applies to all Payers and Providers (together: "Healthcare Entities") approved by HAAD to participate in the Health insurance scheme of Abu Dhabi.
- HAAD Health Insurance Adjudication Standard is available at HAAD website www.haad.ae , Policies and Circulars Section: Reference HSF/CA/1.0, Approval Date Dec/2010.

5.2 Medically Unlikely Edit (MUE)[11]

- Medically Unlikely Edit (MUE), defines the maximum units of service that can be provided to a single beneficiary on a single date of service for a given HCPCS or CPT code, many of which are based on medical and anatomical limitations.
- Table 1 illustrates how MUEs are described. In this example, CPT 44970, laparoscopic surgical appendectomy, has an MUE of 1, indicating this service may only be billed for a single patient once on a single date of service.

Table 1: Example MUE

CPT Code	Descriptor	MUE Edit (maximum frequency of delivery in a single day)
44970	*laproscopic, surgical, appendectomy*	1

- Not all HCPCS or CPT codes have an MUE and thus the publicly available MUEs may not necessarily be comprehensive.
- A table of MUEs is included as a supplemental list in addition to the Mandatory Tariff Pricelist / Tab MUE.
- Insurance companies and Providers opt to utilize the MUE for determination of inappropriate utilization / adjudication purposes, in such case clear indication of utilization of MUE will have to be stated in the Provider Manual section of the Standard Provider Contract.

[11] 2011 MUE: CMS website http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp

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5.3 Abu Dhabi Insurers Simple Edits.

- Simple Edits are required to be shared electronically with HAAD and contracted providers on an ongoing basis. To respect the commercial confidentiality of these edits vis-a-vis other payers, HAAD undertakes not to share these Edits with other Payers/Providers in their native attributed form.
- Following is the listing of the most commonly used simple edits used in the Emirate of Abu Dhabi:

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هيئة الصحة
HEALTH AUTHORITY

Appendix A – Service Codes List

Code	Code Short Description	Code Long Description
1. Accommodation		
Service Codes under the accommodation section are: - Inclusive of room charge, routine nursing and medical supervision, care equipment and systems specific to a special room type, and all items which do not have a valid CPT or code. And - Exclusive of Evaluation and Management, non-routine nursing and medical charges, operation room, all therapies (including respiratory therapy, all physiotherapy, nutritional therapy etc), drugs, diagnostic test, surgeon and anesthetist charges, and medical supplies unless specified otherwise.		
1.1. Room and Board		
17-01	Suite	Daily Room and Board charges for a single room (for the patient) plus one hall (for entertaining guests), each provided with a separate and fully accessible bathroom and inclusive of TV, fridge and seating's for visitors. Patient room is inclusive of a fully automated electric bed, adequate storage space for patient's personal belongings, special table for patient food, medical gases, vacuum, air and suction as well as other features associated with bedside and/or mobile charting, nurse server amenities, access to a private phone and medical specialty based comfort.
17-02	VIP Room	Daily Room and Board charges for a single room with a single fully accessible bathroom accompanied with exclusive measurements for minimal disturbances. Inclusive of a fully automated electric bed, adequate storage space for patient personal belongings, special table for patient food, medical gases, vacuum, air and suction as well as other features associated with bedside and/or mobile charting , nurse server amenities , access to a private phone, TV, fridge and saloon chairs for visitors.
17-03	First Class Room	Daily Room and Board charges for a single room with a single fully accessible bathroom accompanied with exclusive measurements for minimal disturbances. Inclusive of a fully automated electric bed, adequate storage space for patient personal belongings, special table for patient food, medical gases, vacuum, air and suction as well as other features associated with bedside and/or mobile charting , nurse server amenities , access to a private phone, TV, fridge and normal chairs seating arrangement for visitors.
17-04	Shared Room	Daily Room and Board charges for a single room with a single fully accessible bathroom and accommodating 2 single patient beds. Privacy of each bed area is maintained by a segregating screen or curtain and is inclusive of a fully automated electric bed, adequate storage space for the patients personal belongings, special table for patient food, medical gases, vacuum, air and suction as well as other features associated with bedside and/or mobile charting, nurse server amenities and access to a private phone, TV fridge and seating

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		arrangement for visitors.
17-05	Ward	Daily Room and Board charges for a single bed in a room accommodating three patients or more. Privacy of each bed area is maintained by a segregating screen or curtain and is inclusive of adequate storage space for the patients personal belongings, special table for patient food, medical gases, vacuum, air and suction as well as other features associated with bedside and/or mobile charting, nurse server amenities and access to a private phone and seating arrangement for visitors.
17-06	Royal Suite	Daily Room and Board charges for a single room (for the patient) plus 1 or more rooms (for guests), provided with 2 or more separate bathrooms. Inclusive of all possible items for luxury and all possible measurements taken for privacy and exclusivity. Patient room is inclusive of a fully automated electric bed, adequate storage space for personal belongings, special table for patient food, medical gases, vacuum, air and suction as well as other features associated with bedside and/or mobile charting, nurse server amenities and access to a private phone.
17-10	Isolation Room	Daily Room and Board charges for a single bed in a room accommodating one patient or more. Fully equipped to prevent the spread of an infectious agent from an infected or colonized patient to susceptible persons. Inclusive of all of protective barriers and mechanical measurements taken for maintaining isolation.
17-08	Private Room Deluxe	Retired
17-09	Private Room Standard Suite	Retired
1.2. Special Care		
29	Special Care Unit (SCU) or Adult Special-Care Unit (ASCU)	Daily Room and Board charges for the bed occupied by registered adult patient with a need for extra help but not critically ill.
30	Special Care Baby Unit (SCBU)	Daily Room and Board charges for the bed occupied by registered neonate patient (0 to 30 days of age) who is not premature or critically ill but with a need for extra help.
1.3. Nursery		
32	Nursery - General Classification	Daily Room and Board charges for a registered healthy neonate (0 to 30 days of age), who incurs overnight stay for daily room and board in a hospital nursery.
1.4. Intensive Care		
27	Intensive Care Unit (ICU)	Daily Room and Board charges for the bed occupied by a registered patient requiring intensive medical care in an Intensive care unit.
27-01	Coronary Care Unit (CCU)	Daily Room and Board charges for the bed occupied by a registered patient requiring intensive cardiac medical care in a coronary care unit.
28	Neonatal Intensive Care Unit (NICU)	Daily Room and Board charges for the bed occupied by registered premature and/or critically ill neonate patient (0 to 30 days) requiring intensive medical care in an Intensive care unit.
31	Pediatric intensive care Unit (PICU)	Daily Room and Board charges for the bed occupied by registered pediatric patient (1 month to 15 years of age) requiring intensive medical care in an Intensive care unit.

1.5. Other Rooms		
17-21	Emergency Room - Hourly Rate	Hourly rate for the bed / room occupied by registered patient in a hospital or clinic, staffed and equipped to provide emergency care to patient requiring immediate medical treatment.
17-22	Short Stay Room - Hourly Rate	Hourly rate for the bed / room occupied by registered patient who is medically expected to remain confined for less than 6 hours, and equipped with one or more beds; in a patient care unit for the purpose of : i. Assessment, examination, monitoring purposes. ii. For treatments or therapy requiring special equipment, such as removing sutures, draining a hematoma, packing a wound, or performing an examination.
17-23	Recovery Room - Hourly Rate	Hourly rate for the bed / room occupied by registered patient equipped with one or more beds; in a patient care unit which is designated for monitoring post-surgery or post anesthesia patients.
17-24	Short Stay - Daily Rate	Daily rate for the bed / room occupied by registered patient for assessment, examination, monitoring, therapy or Non-invasive / minor procedure for a registered patient: - Medically expected to remain confined for less than 6 hours; - In a Day Care / Day Stay section of the facility, or a patient care unit equipped with one or more beds; - Regardless of the hour of admission, and even if the patient remains in the facility past midnight.
17-25	Day Stay (Day care) - Daily Rate	Daily rate for the bed / room occupied by registered patient for assessment, examination, monitoring, therapy, procedure or surgery (major or minor) for a registered patient: - Medically expected to remain confined for 6 to 12 hours; - In a Day Care / Day Stay section of the facility, or a patient care unit equipped with one or more beds; - Regardless of the hour of admission, and even if the patient remains in the facility past midnight.

Code	Code Short Description	Code Long Description
2. Per-diems		
Refer to section 4.3 of the Claims and Adjudication Rules for the service included in the Pediem codes.		
2.1 Room and Board		
1	Ward or Shared Room - Daily Rate (Day 1 to 3)	Daily all inclusive (as defined in the section 4.3) rate for three days or less of hospital confinement in Ward or Shared Room. Ward or Shared Room specifications are as defined accommodation section, Service code *17-04 and 17-05*.
2	Ward or Shared Room - Daily Rate (Day 4 to 8)	Daily all inclusive (as defined in section 4.3) rate for four to eight days of hospital confinement in Ward or Shared Room. Ward or Shared Room specifications are as defined accommodation section, Service code *17-04 and 17-05*.
3	Ward or Shared Room - Daily Rate (Day 8 and more)	Daily all inclusive (as defined in section 4.3) rate for eight or more days of hospital confinement in Ward or Shared Room. Ward or

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		Shared Room specifications are as defined accommodation section, Service code *17-04 and 17-05*.
3-01	Per Diem Room Rate difference - Daily Rate - Suite	Daily room rate difference between Ward or Shared Room, and Suite room. - Situational code: only billable with Service Codes 1,2 and 3. - Code is inclusive only of the Room and Board charge difference for a Suite Room, as defined in Accommodation section, Service code *17-01*.
3-02	Per Diem Room Rate difference - Daily Rate - VIP Room	Daily room rate difference between Ward or Shared Room and VIP Room. - Situational code: only billable with Service Codes 1,2 and 3. - Code is inclusive only of the Room and Board charge difference for a VIP Room, as defined in Accommodation section, Service code *17-02*.
3-03	Per Diem Room Rate difference - Daily Rate - First Class Room	Daily room rate difference between Ward or Shared Room and First Class Room. - Situational code: only billable with Service Codes 1,2 and 3. - Code is inclusive only of the Room and Board charge difference for a First Class Room, as defined in Accommodation section, Service code *17-03*.
3-06	Per Diem Room Rate difference - Daily Rate - Royal Suite	Daily room rate difference between Ward or Shared Room and Royal Room. - Situational code: only billable with Service Codes 1,2 and 3. - Code is inclusive only of the Room and Board charge difference for a Royal Room, as defined in Accommodation section, Service code *17-06*.
3-10	Per Diem Room Rate difference - Daily Rate - Isolation Room	Daily room rate difference between Ward or Shared Room and an Isolation Room. - Situational code: only billable with Service Codes 1,2 and 3. - Code is inclusive only of the Room and Board charge difference for a Royal Room, as defined in Accommodation section, Service code *17-10*.
17-17	Per Diem - Category 17	Retired Code
17-18	Per Diem - Category 18	Retired Code
17-19	Per Diem - Category 19	Retired Code
17-20	Per Diem - Category 20	Retired Code
2.2 Intensive Care		
5	NICU - Daily Rate (Day 1 to 7)	Daily all inclusive (as defined in section 4.3) rate for day one to seven of hospital confinement of registered premature and/or critically ill neonate patient (0 to 30 days of age) in Neonatal Intensive Care Unit (NICU). NICU specifications are as defined in accommodation section, Service code *28*.
6	NICU - Daily Rate (Day 8 to 14)	Daily all inclusive (as defined in section 4.3) rate for day eight to fourteen of hospital confinement of registered premature and/or critically ill neonate patient (0 to 30 days of age) in Neonatal Intensive Care Unit (NICU). NICU specifications are as defined in accommodation section, Service code *28*.
7	NICU - Daily Rate (Day 15 to 21)	Daily all inclusive (as defined in section 4.3) rate for day fifteen to twenty one of hospital confinement of registered premature and/or critically ill neonate patient (0 to 30 days of age) in Neonatal Intensive

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		Care Unit (NICU). NICU specifications are as defined in accommodation section, Service code *28*.
8	NICU - Daily Rate (Day 22 and more)	Daily all inclusive (as defined in section 4.3) rate for day twenty two to discharge of hospital confinement of registered premature and/or critically ill neonate patient (0 to 30 days of age) in Neonatal Intensive Care Unit (NICU). NICU specifications are as defined in accommodation section, Service code *28*.
17-07	PICU - Daily Rate (Day 1 to 7)	Daily all inclusive (as defined in section 4.3) rate for day one to seven of hospital confinement of registered premature and/or critically ill pediatric patient (1 month to 15 years of age) in Special Pediatric Intensive Care Unit (PICU). PICU specifications are as defined in accommodation section, Service code *31*.
17-07-01	PICU - Daily Rate (Day 8 to 14)	Daily all inclusive (as defined in section 4.3) rate for day eight to fourteen of hospital confinement of registered and critically ill pediatric patient (1 month to 15 years of age) in Special Pediatric Intensive Care Unit (PICU). PICU specifications are as defined in accommodation section, Service code *31*.
17-07-02	PICU - Daily Rate (Day 15 to 21)	Daily all inclusive (as defined in section 4.3) rate for day fifteen to twenty one of hospital confinement of registered and critically ill pediatric patient (1 month to 15 years of age) in Special Pediatric Intensive Care Unit (NICU). NICU specifications are as defined in accommodation section, Service code *31*.
17-07-03	PICU - Daily Rate (Day 22 and more)	Daily all inclusive (as defined in section 4.3) rate for day twenty two and more of hospital confinement of registered and critically ill pediatric patient (1 month to 15 years of age) in Special Pediatric Intensive Care Unit (PICU). PICU specifications are as defined in accommodation section, Service code *31*.
4	ICU/CCU - Daily Rate (Day 1 to 7)	Daily all inclusive (as defined in section 4.3) rate for day one to seven of hospital confinement of registered and critically ill patient (more than 15 years of age) in Intensive Care Unit (ICU). ICU specifications are as defined in accommodation section, Service code 27.
4-01	ICU/CCU - Daily Rate (Day 8 to 14)	Daily all inclusive (as defined in section 4.3) rate for day eight to fourteen of hospital confinement of registered premature and/or critically ill patient (more than 15 years of age) in Intensive Care Unit (ICU). ICU specifications are as defined in accommodation section, Service code 27.
4-02	ICU/CCU - Daily Rate (Day 15 to 21)	Daily all inclusive (as defined in section 4.3) rate for day fifteen to twenty one of hospital confinement of registered and critically ill pediatric patient (more than 15 years of age) in Intensive Care Unit (ICU). ICU specifications are as defined in accommodation section, Service code 27.
4-03	ICU/CCU - Daily Rate (Day 22 and more)	Daily all inclusive (as defined in section 4.3) rate for day twenty two and more of hospital confinement of registered and critically ill pediatric patient (more than 15 years of age) in Intensive Care Unit (ICU). ICU specifications are as defined in accommodation section, Service code 27.
2.3 Nursery		
17-12	Newborn Nursery (Day 1 to 3)	Daily all inclusive (as defined in section 4.3) rate for day one and three of hospital confinement of registered healthy neonate patient (0 to 30

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		days of age) in a hospital nursery. Hospital nursery specifications are as defined in accommodation section, Service code 32.
17-12-01	Newborn Nursery (Day 4 to 8)	Daily all inclusive (as defined in section 4.3) rate for day four and eight of hospital confinement of registered healthy neonate patient (0 to 30 days of age) in a hospital nursery. Hospital nursery specifications are as defined in accommodation section, Service code 32.
17-12 -02	Newborn Nursery (Day 9 and more)	Daily all inclusive (as defined in section 4.3) rate for day nine and more of hospital confinement of registered healthy neonate patient (0 to 30 days of age) in a hospital nursery. Hospital nursery specifications are as defined in accommodation section, Service code 32.
2.4 Special Care		
18	SCU (Day 1 to 3)	Daily all inclusive (as defined in section 4.3) rate for day one and three of hospital confinement of registered adult patient who is not critically ill but is requiring of special medical attention in a Special Care Unit. Special Care Unit specifications are as defined in accommodation section, Service code 29.
18-01	SCU (Day 4 to 8)	Daily all inclusive (as defined in section 4.3) rate for day four and eight of hospital confinement of registered adult patient who is not critically ill but is requiring of special medical attention in a Special Care Unit. Special Care Unit specifications are as defined in accommodation section, Service code 29.
18-02	SCU (Day 9 and more)	Daily all inclusive (as defined in section 4.3) rate for day nine and more of hospital confinement of registered adult patient who is not critically ill but is requiring of special medical attention in a Special Care Unit. Special Care Unit specifications are as defined in accommodation section, Service code 29.
19	SCBU (Day 1 to 3)	Daily all inclusive (as defined in section 4.3) rate for day one and three of hospital confinement of registered neonate patient (0 to 30 days of age) who is not critically ill but is requiring of special medical attention in a Special Care Baby. Special Care Baby Unit specifications are as defined in accommodation section, Service code 30.
19-01	SCBU (Day 4 to 8)	Daily all inclusive (as defined in section 4.3) rate for day four and eight of hospital confinement of registered neonate patient (0 to 30 days of age) who is not critically ill but is requiring of special medical attention in a Special Care Baby. Special Care Baby Unit specifications are as defined in accommodation section, Service code 30.
19-02	SCBU (Day 9 and more)	Daily all inclusive (as defined in section 4.3) rate for day nine and more of hospital confinement of registered neonate patient (0 to 30 days of age) who is not critically ill but is requiring of special medical attention in a Special Care Baby. Special Care Baby Unit specifications are as defined in accommodation section, Service code 30.
2.5 Long Term Stay		
17-13	Long Term Stay (Simple Cases)	Daily all inclusive (as defined in section 4.3) rate of hospital/nursing home confinement of registered patient who fall under the category of simple cases as defined by the HAAD Long Term Care Standard.
17-14	Long Term Stay (Intermediate Cases)	Daily all inclusive (as defined in section 4.3) rate of hospital/nursing home confinement of registered patient who fall under the category of Intermediate cases as defined by the HAAD Long Term Care Standard.

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17-15	Long Term Stay (Intensive Cases)	Daily all inclusive (as defined in section 4.3) rate of hospital/nursing home confinement of registered patient who fall under the category of Intensive cases as defined by the HAAD Long Term Care Standard.
17-16	Long Term Stay (Severe Cases)	Daily all inclusive (as defined in section 4.3) rate of hospital/nursing home confinement of registered patient who fall under the category of Severe cases as defined by the HAAD Long Term Care Standard.
2.6 Short Stay, Day Stay and other rooms		
15	Perdiem - Treatment or Observation Room - NOT inclusive of Laboratory and Radiology	- Retired Code
16	Perdiem - Day Stay (Day Care) Room - NOT inclusive of Laboratory and Radiology	- Retired Code
24	Perdiem - Short Stay	Daily all inclusive (as defined in section 4.3) rate for services provided for assessment, examination, monitoring, treatment or therapy purposes for a registered patient: - Medically expected to remain confined for less than 6 hours; - In a patient care unit equipped with one or more beds. - Regardless of the hour of admission, and even if the patient remains in the facility past midnight.
25	Perdiem - Day Stay (Day care) - Inclusive.	- Retired Code
25-01	Perdiem-Day Stay - Medical Case	Daily all inclusive (as defined in section 4.3) rate for assessment, examination, monitoring, therapy or Non-invasive / minor procedure for a registered patient: - Medically expected to remain confined for 6 to 12 hours; - In a Day Care / Day Stay section of the facility, or a patient care unit equipped with one or more beds; - Regardless of the hour of admission, and even if the patient remains in the facility past midnight.
25-02	Perdiem-Day Stay - Surgical Case	Daily all inclusive (as defined in section 4.3) rate for assessment, examination, monitoring, therapy; including pre-, intra and post-operative care-provided in the same day- of major procedures or surgical interventions provided for a registered patient: - Medically expected to remain confined for 6 to 12 hours;. - In a Day Care / Day Stay section of the facility, or a patient care unit equipped with one or more beds. - Regardless of the hour of admission, and even if the patient remains in the facility past midnight.
2.7 Dialysis		
14-01	Per Diem- Hemodialysis (HD).	Daily all inclusive rate for out-patient hemodialysis in a dialysis center provided for a registered patient. Inclusive of: - In-center initial and routine patient assessment by a clinician (doctor, nurse or qualified technician) prior to, during or after dialysis treatment. - Professional charge for performance of hemodialysis. - Patient and family education and support concerning renal disease, dialysis treatment, diet, lifestyle and social aspects.

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		- Usage of equipment required for the performance of the Hemodialysis. - All disposable products and supplies required for the performance of the Hemodialysis. - Medical supervision (on-site or remote) of the dialysis by qualified physician - Pharmaceuticals routinely required in the performance of the dialysis treatment Routine investigation s and diagnostic tests recommended for patient on hemodialysis treatment.
14-02	Per Diem- Automated Peritoneal Dialysis (APD).	An all-inclusive monthly rate, triggered by an individual out-patient "*Automated Peritoneal Dialysis*" encounter, provided in a dialysis center for a registered patient. Inclusive of: - In-center initial and routine patient assessment by a clinician (doctor, nurse or qualified technician) prior to, during or after treatment, and / or Patient training, retraining and family education for self-administration of Automated Ambulatory Peritoneal Dialysis, as well as education and support concerning renal disease, dialysis treatment, diet, lifestyle and social aspects - Rental of equipment required for the performance of the Automated Peritoneal Dialysis, for a full month. - All disposable products and supplies required for the performance of the Automated Peritoneal Dialysis, for a full month. - Medical supervision (on-site or remote) of the dialysis by qualified clinicians. - Pharmaceuticals routinely required in the performance of the Automated Peritoneal Dialysis treatment, for a full month.. - Routine investigations and diagnostic tests recommended for patient on Automated Peritoneal Dialysis treatment
14-03	Per Diem- Continuous Ambulatory Peritoneal Dialysis (CAPD).	An all-inclusive monthly rate, triggered by an individual out-patient *"Continuous Ambulatory Peritoneal Dialysis"* encounter, provided in a dialysis center for a registered patient. Inclusive of: - In-center initial and routine patient assessment by a clinician (doctor, nurse or qualified technician) prior to, during or after treatment, and/or - Patient training, retraining and family education for self-administration of Continuous Ambulatory Peritoneal Dialysis, as well as education and support concerning renal disease, dialysis treatment, diet, lifestyle and social aspects - All disposable products and supplies required for the performance of the dialysis treatment, for a full month. - Medical supervision (on-site or remote) of the dialysis by qualified clinicians. - Pharmaceuticals routinely required in the performance of the Continuous Ambulatory Peritoneal Dialysis treatment, for a full month

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		- Routine investigations and diagnostic tests recommended for patient on Continuous Ambulatory Peritoneal Dialysis treatment
3. Consultations		
9	Consultation GP	- Code Retired
9.1	Consultation GP – Follow up	- Code Retired
10	Consultation Specialist	- Code Retired
10.1	Consultation Specialist – Follow up	- Code Retired
11	Consultation Consultant	- Code Retired
11.1	Consultation Consultant – Follow up	- Code Retired
21	Home visit - G.P consultation	- Code Retired
22	Home visit - Specialist consultation	- Code Retired
23	Home visit - Consultant consultation	- Code Retired
4. Operating Room Services		
20	Operating Room Services - General Classification	Operating room inclusive of the Pre-medication room, Operating block, Anesthesia substance (consumables, gases etc), sterilization, respiratory and cardiac support, and emergency resuscitative devices, patient monitors, diagnostic tools, all consumables and drugs. Not inclusive of the anesthetist Doctor charge.
20-01	Operating Room - Minor Surgery	Operating room for a simple or minor procedure inclusive of the Pre-medication room, Operating block, Anesthesia substance (consumables, gases etc), sterilization, respiratory and cardiac support, and emergency resuscitative devices, patient monitors, diagnostic tools, all consumables, **operation room's devices** and drugs utilized in the operation room. Not inclusive of the anesthetist Doctor charge.
20-02	Operating Room - First Hour	Operating room for complex procedure or surgery, first hour rate. - Inclusive of the Pre-medication room, Operating block, Anesthesia substance (consumables, gases etc), sterilization, respiratory and cardiac support, and emergency resuscitative devices, patient monitors, diagnostic tools, all consumables, **operation room's** devices and drugs utilized in the operation room. . - Not inclusive of the anesthetist Doctor charge.
20-03	Operating Room - Every Additional 1/2 hour	Operating room for complex procedure or surgery, every additional ½ hour. - Can only be billed with code 20.02. - Inclusive of the Pre-medication room, Operating block, Anesthesia substance (consumables, gases etc), sterilization, respiratory and cardiac support, and emergency resuscitative devices, patient monitors, diagnostic tools, all consumables, operation room's devices and drugs utilized in the operation room. - Not inclusive of the anesthetist Doctor charge.
20-04	Catheterization Lab	Catheterization Lab room for complex cardiac procedure or surgery. - Inclusive of the Pre-medication room, Operating block, Anesthesia substance (consumables, gases etc), sterilization, respiratory and cardiac support, and emergency resuscitative devices, patient monitors, diagnostic tools, all consumables,

		operation room's devices and drugs utilized in the operation room. - Not inclusive of the anesthetist Doctor charge.
20-05	Delivery Room	Hospital room equipped for childbirth; inclusive of all the birthing devices including but not limited to Fetal/Patient monitors, Forceps, Curettes, Surgical equipment, Sterilization, Emergency devices all consumables and drugs.
5. Other Services		
17-11	Per Diem - Non- Medical Escort accommodation -	Daily Rate. Accommodation stays in hospital or outside hospital (at reasonable and customary charges) for a single escort accompanying the patient outside Abu Dhabi. Exclusive of food and telephone charges. Charged per day. See Mandatory price list & Rules.
17-11-1	Per Diem - Medical Escort accommodation - Daily Rate	Daily Rate. Accommodation stays in hospital or outside hospital (at reasonable and customary charges) for a single medical professional accompanying the patient outside Abu Dhabi. Exclusive of food and telephone charges. Charged per day. See Mandatory price list & Rules.
17-11-2	Per Diem - International Assistance in case of Emergency	Daily Rate. Costs for providing emergency assistance during critical illness, & accident outside UAE. Including travel, security, medical assistance & local expertise in the country of treatment. See Mandatory price list & Rules.
12	Undefined services	Undefined service.
26	Per Diem - Companion Accommodation	Daily Rate. Per day room and board charges in hospital / treating facility for (1) a person accompanying a registered inpatient insured, of any age that is critically ill, or (2) parent accompanying a child under 10 years of age.
50-01	Comprehensive screening evaluation and management by clinician of an individual, including an age and gender appropriate history, questionnaire filling, examination, and ordering of laboratory/diagnostic procedures, new or established patient; 30-40 minutes.	
51-01	Non-surgical cleansing of a wound without debridement, with or without local anesthesia, with or without the application of a surgical dressing: 16 sq inches / 100 sq centimeters or less.	
51-02	Non-surgical cleansing of a wound without debridement, with or without local anesthesia, with or without the application of a surgical dressing: between 16 sq inches / 100 sq centimeters and 48 sq inches / 300 sq centimeters .	
51-03	Non-surgical cleansing of a wound without debridement, with or without local anesthesia, with or without the application of a surgical dressing: more than 48 sq inches / 300 sq centimeters.	
99	Outlier Payment	Outlier Payment. See IR-DRG Standard at www.haad.ae

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Appendix B – CPT Codes Ranges.

Note: refer back to section 2.4.2 "Multipliers Application Rules" for the use of the CPT Codes Ranges

Service Category	Codes Range	
	from	To
Evaluation And Management:	99201	99499
Psychiatry	90801	90899
Dialysis	90935	90999
Gastroenterology	91000	91299
Ophthalmology	92002	92499
Special Otorhinolaryngologic Services	92502	92700
Cardiovascular	92950	93799
Noninvasive Vascular Diagnostic Studies	93875	93990
Pulmonary	94002	94799
Allergy & Clinical Immunology	95004	95199
Endocrinology	95250	95251
Neurology & Neuromuscular Procedures	95803	96020
Central Nervous System Assessments/Tests	96101	96125
Health & Behaviour Assessment/Intervention	96150	96155
Injections & Infusions, and Chemotherapy Administration	96360	96549
Photodynamic Therapy	96567	96571
Special Dermatological Procedures	96900	96999
Physical Medicine & Rehabilitation	97001	97799
Medical Nutrition Therapy	97802	97804
Acupuncture	97810	97814
Osteopathic Manipulative Treatment	98925	98929
Chiropractic Manipulative Treatment	98940	98943

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Education & Training For Patient Self-Management	98960	98962
Special Services, Procedures And Reports	98966	99091
Qualifying Circumstances For Anesthesia	99100	99140
Moderate (Conscious) Sedation	99143	99150
Other Services & Procedures	99170	99199
Home Health Procedures/Services	99500	99602
Medication Therapy Management Services	99605	99607
Immunization Administration For Vaccines/Toxoids	90465	90474
Biofeedback	90901	90911
Anaesthesia:	00100-01999; 99100-99150	
Surgery: 10021-69990 or		
General	10021	10022
Integumentary System	10040	19499
Musculoskeletal System	20000	29999
Respiratory System	30000	32999
Cardiovascular System	33010	37799
Hemic & Lymphatic Systems	38100	38999
Mediastinum & Diaphragm	39000	39599
Digestive System	40490	49999
Urinary System	50010	53899
Male Genital System	54000	55899
Reproductive System & Intersex	55920	55980
Female Genital System	56405	58999
Maternity Care & Delivery	59000	59899
Endocrine System	60000	60699
Nervous System	61000	64999
Eye & Ocular Adnexa	65091	68899
Auditory System	69000	69979

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Radiology: 70010-79999 or		
Diagnostic Imaging	70010	76499
Diagnostic Ultrasound	76506	76999
Radiologic Guidance	77001	77032
Breast Mammography	77051	77059
Bone/Joint Studies	77071	77084
Radiation Oncology	77261	77799
Nuclear Medicine	78000	79999

Pathology & Laboratory: 80047-89398 or		
Organ Or Disease-Oriented Panels	80047	80076
Drug Testing	80100	80103
Therapeutic Drug Assays	80150	80299
Evocative/Suppression Testing	80400	80440
Consultations (Clinical Pathology)	80500	80502
Urinalysis	81000	81099
Chemistry	82000	84999
Hematology & Coagulation	85002	85999
Immunology	86000	86849
Transfusion Medicine	86850	86999
Microbiology	87001	87999
Anatomic Pathology (Postmortem)	88000	88099
Cytopathology	88104	88199
Cytogenetic Studies	88230	88299
Surgical Pathology	88300	88399
In Vivo (Transcutaneous) Lab Procedures	88720	88741
Other Procedures	89049	89240
Reproductive Medicine Procedures	89250	89398